

**“A Force to be Reckoned With”: Senior Women Medical and Basic Science Faculty
Negotiating Self and Environment to Manage Success**

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Submitted to the Graduate Degree Program in Sociology and the Graduate Faculty at the
University of Kansas in partial fulfillment of the requirements for the degree of Master of Arts

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Date Defended April 11, 2014

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Date approved: April 22, 2014

Abstract

Women in the medical and basic science fields are still entering a male dominated space when they enter into the academy. Two main questions guide this research: 1) what are the experiences of female academic medical and basic sciences professors in a male dominated environment? And 2) what strategies did they enact in order to manage their success in the male dominated environment? This is a qualitative project studying twenty-six senior women faculty at a large Midwestern medical center. The qualitative method allows for a deeper look into narratives of women to better understand what happened in their experiences. Most but not all of the women in this study experienced isolation and exclusion, sexual harassment, and/or pressures to perform the “second shift” (Hochschild 2012). These women worked to negotiate their professional identities with strategies of appearing easy-going and carefully constructing their femininity in order to downplay their difference based on gender in the professional realm. Women also explained their success as based on being exceptional and/or hardworking in a meritocracy that is not based on gender.

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Introduction

Even though women now make up over fifty percent of many medical and basic science graduate school classes, parity to men at the leadership and full professor level is stagnant at thirty five percent for medicine (Levine et al 2011) and sixteen percent for basic science (Rosser 2011). Although many studies have shown a changing landscape of gender parity in medicine and science, gender hierarchy and a lack of equality at the leadership level continues to exist (Ash et al. 2004; Carnes, Morrissey and Geller 2008; Martin, Arnold, and Parker 1988; Nonnemaker 2000; Reed and Buddeberg-Fischer 2001; Riska 2001). Social theorists have considered causes for the scarcity of women in higher levels of the medical and basic science academy to be a result of sexual harassment of women in medical and graduate school (Babaria et al. 2012; Campbell 1973; Kass, Souba, and Thorndike 2006; Lorber and Moore 2002; Quadagno 1976), a lack of representation of women in leadership roles in medical and basic science academia (Levine et al 2011; Rosser 2001), a lack of mentoring opportunities for women in medical and graduate school (Bickel 1995; Levine et al. 2011, Yedida and Bickel 2001) a woman's subspecialty choice (Lorber 2002; Quadagno 1976), women in medicine and science opting for part time work (Reed and Buddeberg-Fischer 2001), and women's role in the childcare and family matters (Carr and Ash 1998; Reed and Buddeberg-Fischer 2001; Rosser 2001; Yedida and Bickel 2001). Thus, a review of the literature in order to understand how women are treated as not belonging, or "othered" (Campbell 1973) in organizations that are male-typed, generally, and how women are treated in academic medicine and basic science, specifically, is needed in order to locate this research in an ongoing conversation about professional women.

Women as the “Other”

Specifically, organizational theorists such as Kanter (1977), Acker (1990), and Williams et. al (2012) show in their research that organizational structure is itself gender typed, as in, the ideal worker is “gender neutral” which reads as “male”. To be clear, the use of the term “othering” (Campbell 1973) in this paper is meant to convey that when women enter predominantly male spaces, they are seen as the anomaly or token. The female “other” refers to that which is different than the typical, prevailing male incumbent in social spaces. But Britton’s (2000) question is relevant when she asks, “What does it really mean to say that an organization is gendered” (pg 419). Science and medicine has, like any other public professional realm, been touted as the rational, competitive, non-emotional and independent fields well suited for men, as the cultural idea of what is masculine has coincided with these traits.

Kanter’s work on managers illustrated that a good manager has masculine traits, which makes the terms “male” and “manager” almost interchangeable (Kanter 1977). Conversely, the cultural idea of the feminine traits of dependence, emotionality, passivity and sensitivity have been relegated to women, and thus women have been historically considered inept for a career in male typed fields such as business, medicine, science, and academics. Additionally, the way women are “marked” (by dress, style, or even language) is a way in which women are distinctive while men go “unmarked” can lead to their exclusion (Tannen 1993). Thus, we can see how women entering the “masculine” spaces of medicine and science would be deemed unusual, perhaps even today.

Acker’s (1990) argument that organizations are *inherently* gendered echoes the above theorists in their assertion that to be male is to be “typical” and to be female is to be “a-typical.”

Taken further, Acker's argument explains how women are disenfranchised in the organization and thus need to work against that disenfranchisement. Acker states that even the "meaning and identity (in the organization) are patterned through and in terms of distinction between male and female" (pg 146), thus echoing Kanter's (1977) findings that there are distinctions that have gendered outcomes in the organization.

The Second Shift and Women as Mothers

It is argued that women are still seen as better suited for mothering and mother-work above all else. Ruddick (1980) explains that the social construction of women-as-mothers is based on the historical incidences of women having been relegated to mothering and housework alone during the industrial era of the late nineteenth century. This socio-historic placement of women in the economic structure in turn created a social construction of femininity that coincided with the perceived innate attributions of women as caring, nurturing, and willing mothers (Ruddick 1980). Thus, women can be seen as atypical when they desire to enter the public realm of professional paid work. Also, they are expected to "mother" while in these professional realms, which create in them an "other" against the ideal worker as unfettered and non-competitive (the male worker traits).

This kind of double standard for women is what Hochschild (2012) was discussing when she examined how societal norms expect some workers (usually women) to display empathy and caring on the job, which she termed emotion work. A piece that contributes to these societal norms is the gendered status and socialization of girls and women, which then leads to women as beholden to a larger display of emotion work because it is culturally and socially inscribed. This emotional habitus then creates a self-fulfilling prophecy, when

women are more able to convey emotion and perform emotion work, which in turn leads to the greater marginalization of women *as emotional*. Therefore, women are seen as the “other” against the stereotype of men as non-emotional and rational.

Women in Medicine and Science

Historically, women have been underrepresented in professional organizations based on their status as mothers and the construction of professions as masculine, but in medicine and science specifically, there are main themes found in the literature addressing the lack of women in those spaces. Most specifically, a lack of representation of women throughout the academic tenure track can have troubling outcomes for women, in that women have to deal with experiences of sexual harassment and sex discrimination, difficulty negotiating a work life balance, and the need to take part time work so that she can perform the second shift. Therefore, the most troubling aspect of these trends is that women are still being seen as not fitting into these spaces. The literature has shown how women experience these work environments differently than men.

Although many scholars have attempted to understand the impact of gender on advancement in medicine and basic science, the “leaky pipeline” of women professors in medicine and basic science still ensures that more women than men leave academe (Speck et al. 2005). The contradictions between higher numbers of women in graduate and medical school classes but a lack of parity with men at the leadership level can be explained by understating how women are still placed opposite against the male archetype. This is also seen when nurses or students refer to a woman physician as the “lady doctor” (Floge and Merrill 1986) so in essence, women are still seen as different. An later study (1996) did show an advancement of more

women in academic medicine, but reported two serious trends: one, that women reported a much higher level of isolation in the department than did men, and two, that women acknowledged subtle interactions in the department that were hostile or intimidating. Therefore, it's not surprising that 66% of the women surveyed also reported that they were seriously considering leaving academia (Fried et al. 1996). Conversely, a study on the discontent in the academy that medical school faculty experienced stated that gender was not factor in predicting an academic physician would leave academic medicine (Lowenstein, Fernandez and Crane 2007). However, it is noteworthy that even when controlling for gender, women physicians received less salary and fewer rewards for their work than men of the same rank and experience (Carr et al. 1993; Kaplan et al. 1996).

Isolation and Exclusion

Discrimination as a part of the medical school experience is something that women must contend with, and one study shows that women are significantly more likely than men to report feelings of gender discrimination (Tolbert Coombs and King 2005). Additionally, women in medicine are shown in previous research to be viewed as “significantly less confident” than their male counterparts (Blanch et al. 2008; Carr et al. 2003). Women are also seen as less tenacious (because of their childhood socialization) than men in the medical academy (Yedida and Bickel 2001). Ceci, Williams, and Barnett (2009) found that women in science are evaluated more harshly in post-doctoral positions, which can lead to less female representation in the academy, as in the sciences post-doctoral positions are often necessary to receive academic appointment. It has also been shown that students are affected by how gender issues are handled within the environment of their educational institutions, and may not persist if they felt ostracized (Zimmerman 2000). Women in these institutions are savvy

enough to realize when they are unwanted in the male dominated space, even if the men do not strive to give that impression.

More current research has confirmed that this gendered bias in the medical academy holds true, and that more women than men perceived that they were, “constantly under scrutiny by colleagues, that they worked harder than colleagues worked in order to be perceived as legitimate, and that there were ‘unwritten rules’ and bias against women.”(Shollen et al. 2009). In an interview study of medical clinical department chairs on reasons that women do not succeed in the medical academy to the same degree of men, nearly half of the chairs that participated in the study said that women are behind in leadership because only recently have women begun to attend medical school in larger numbers. They were also opposed to any sort of special efforts to increase the number of women leaders in the academy, with one man saying that by pushing the issue, it would cause more problems (Yedida and Bickel 2001). This type of heightened scrutiny and lack of support will place unneeded stress and act as a gatekeeper for women that strive to enter professional realms that have been historically (and even more contemporarily) male dominated.

If a female student does not have any professors that are women in either medical or graduate school, the message is clear: women need not apply. Women will feel as though they are outsiders in a cold institutional climate that does not include them (Ceci, Williams, and Barnett 2009). These are arguably significant factors in a culture of male domination in which women either feel or are perceived as less capable than their male colleagues. In one study, forty percent of women responded that gender discrimination hindered their career in academic medicine, with thirty five percent listing gender discrimination as the second most contributing reason to their lack of success (Carr et al. 2003; Shrier et al. 2007).

Unsurprisingly, in a survey study of both women and men faculty, women were more likely to cite discrimination as a reason for less advancement of women in basic science, while men were least likely to say the same (as in, men did not agree that discrimination was the reason for a lack of women in advanced positions in the academy) (Ecklund, Lincoln, and Tansey 2012).

These problematic attributes of the medical and basic science academy are also directly related to a dearth of mentoring that women need. Previous research has developed a strong argument regarding for the lack of sufficient mentoring experience for women students and junior academics in medicine and basic science, and how it affects junior academics' advancement (Ecklund, Lincoln, and Tansey 2012; Kass et al. 2006; Levine et al. 2011, Rosser 2011; Yedida and Bickel 2001). Many senior women have declared the relationship they had with a mentor to be a key factor in their success (Rosser 2011). The converse is true as well; a shortage of mentoring has been shown to negatively impact women in medicine (Levine et al. 2011, Yedida and Bickel 2001) and science (Ecklund, Lincoln, and Tansey 2012). However, if women must do the extra work to negotiate these medical and basic science settings, mentoring is just one piece of the equation that will affect the parity of women. Yet, attention should be paid to the mentoring situation of women because of the scarcity of senior and tenured women in medicine and basic science, which creates a bottleneck of women who are of mentor quality and the women who desire their mentorship.

Problems that contribute to women's lack of parity in advancement is another area in which researchers have attempted to understand the setting of medical and basic science academics for women (Riska 2001). One research project found that women are perceived as disadvantaged in matters of negotiation around salary, work resources, and schedules

(Sambuco et al. 2013). Westring and colleagues (2012) attempted to understand how the culture of a woman academic physician or basic scientist's department is more or less conducive to the assistant professor's success. Results show that four facets are needed: the department provides equal access to opportunities and resources, the department encourages work-life balance, the department facilitates the discussion and elimination of gender biases, and that the chair or chief is supportive. The problems women encounter on the way to advancement create the funneling effect so that women are not becoming tenured, full professors at the same rate and in the same numbers as men. Without the sort of equal balance at the top ranks of the institution, gender will still be a disadvantage for women in academic medicine and basic science careers.

So even with a proliferation of women in medical and basic science graduate schools than ever before, women are still encountering challenges of under-representation in advanced levels of academic medicine and science, problems with self-esteem, and stereotypes of a woman's fit in certain fields and subspecialties (Ash et al. 2004; Blanch et al. 2008; Brooks 1998). These characteristics of the medical and graduate school and then the faculty experience undoubtedly contribute to a woman's savvy realization of the ways she must negotiate the self and environment.

Sexual Harassment and Sex Discrimination

Another way in which women are relegated to a marginal status is sexism. Sexism, in medical and graduate school, can directly affect a woman's choice of subspecialty (Babaria et al. 2012; Campbell 1973; Kass, Souba, and Thorndike 2006; Lorber and Moore 2002; Quadagno 1976) with outright hostility barring women from considering the more male dominated

subspecialties of surgery or urology. The inverse to this is the positive affirmations women receive when choosing “female friendly” subspecialties such as pediatrics, dermatology, or family medicine (Babaria et al. 2012; Brooks 1998; Quadagno 1976). One of the most confounding trends seen with the influx of women into the traditionally male fields of medicine and basic science is that stereotypes of male and female subspecialties are a mainstay instead of a thing of the past (Babaria et al. 2012; Quadagno 1976).

In 1976, Quadagno asked how women were socialized into the occupational structure of a career in medicine. Looking at the occupational culture of physicians, she examined the ways in which values influenced by culture and the social structures people find themselves in work to influence a doctor’s choice of subspecialty. Her finding was that experiences in medical school influence women to choose certain subspecialties based on observations the women reported of other women who attempted to enter male dominated specialties and of women who chose to enter female dominated subspecialties. Female doctors who choose specialties that are amenable to women are given positive feedback from peers, while women are encouraged not to choose more “male” (especially surgical) specialties (Quadagno, 1976).

This trend is arguably still seen today in sexist experiences of women medical and graduate students. Women are characterized as tender, empathetic, temperamental, and lenient and thus a funneling effect occurs into subspecialties that seem to utilize these types of traits (Floge and Merrill 1986; Kass, Souba, and Thorndyke 2006; Martin, Arnold, and Parker 1988; Nora et. al 2002; Shrier et al. 2007). However, a woman may not exhibit feminine personality traits, but a women’s *embodied* difference creates a need for a female to dress or present a certain way in order to downplay her difference *as woman* (Babaria et al. 2012) and this troubling aspect of gendering implications ensures that it is not simply a matter of equal

access to erase difference. This “difference” in women directly leads to underrepresentation of women in particular fields and subspecialties.

Thus, gendered pathways still exist in medicine and science such that women are encouraged to choose subspecialties by the positive reinforcement of “feminized” subspecialties and encounter hostility in male dominated subspecialties. Women that enter medical or graduate school quickly learn by looking around that certain sub-specialties are more amenable to women than others (Ecklund, Lincoln, and Tansey 2012). This in effect supplies a pipeline of women into traditionally female friendly subspecialties. The archetype of “doctor” in the United States has long been understood as “white male” (Quadagno 1976). Basic science is much the same way. Women report being discouraged of pursuing science as a career based on feeling anxious about conforming to stereotype about their gender, the inability to reconcile work and family, and a lack of educational preparedness for the scientific fields (Ceci, Williams, and Barnett 2009).

Work Life Balance and Part Time Work

Over time, research on a woman’s experience in medical and graduate school has shown that women acknowledge the second shift, or the perceived expectation that they will perform a majority of the household and family responsibilities, and that women choose a subspecialty that is cooperative to those tasks (Brooks 1998; Campbell 1973; Miller, Kemmelmeier and Dupey 2013). Specifically, some women scientists acknowledge that working in academia is unamenable to their role of mothering, and thus choose to work in industry instead (Rosser 2011). In one study, it was shown that women with children in academic medicine do not publish as often and had lower career satisfaction than their male

counterparts (Carr and Ash 1998). Shollen et. al (2009) also found the effect of lower career satisfaction in women faculty due to the second shift effect (family and home responsibilities), but also found that these women were more likely to have higher attrition as well.

Following this line of inquiry, part time work is an aspect of women's professional experience that has led to skewed advancement (Reed and Buddeberg-Fischer 2001). The fact that women work part time more often than men is related to how women are still largely responsible for a majority of the care of home and family. This "second shift" engineers circumstances for women that prompts them to reconcile work and family differently than men (Levine et al. 2011), which means women will work part time outside of the home in order to fulfill all the roles expected of them (Lawrence and Corwin 2003). Another study found that the highest attrition rates were for women in research track or clinical track careers, as opposed to tenure track (Speck et al. 2012), suggesting that women in the tenure track are most disadvantaged regarding family responsibilities.

The literature on a woman's experiences in academic medicine and basic science, as well as theoretical background that examines how women are made different in organizations is useful for understanding how women are treated in professional settings even today. In sum, the above review has considered how the absence of true parity for women in medicine and science is constructed and continues, and how the role of gendered processes in the organization and work life balance issues explain this inequality. Previous research has not demanded an examination of how women traverse a gendered environment by not only assessing the environment but negotiating between presentation of self and navigation of environment for persistence and success (see Kass et. al 2006 for one exception on women

surgical leaders). The review also examines the way that a woman's difference in the social institution of medical and basic science academy has led to less representation in the leadership and senior levels of tenure and advancement. Qualitative work reviewed described how women felt about and their experiences in academic medicine and basic science, but did not analyze how women move through these spaces without becoming ostracized in order to persist.

Among all of the issues shown in the literature that women must contend with, it seems that these are very unwelcoming environments for women. However, some women do persist and become senior, fully tenured professors. Therefore I ask two main questions: 1) what are the experiences of female academic medical and basic sciences professors in a male dominated environment? And 2) what strategies did they enact in order to manage their success in the male dominated environment? An analysis to examine the experiences of women and how she negotiates the self and environment would benefit the scholarly dialogue here by adding more contextual knowledge to women's experiences in professional settings that have been historically and contemporarily dominated by men. The purpose of this study is to better understand how women in academic medicine and basic science departments enact a negotiation between self and environment and to understand their experiences in these spaces.

Methods

Study Design and Sample

To study women's experiences as medical and basic scientist academicians, I utilized oral history qualitative face to face interviews (Swain 2003) with a grounded theory analysis

(Glaser and Strauss 1967). The oral history tradition of qualitative interviewing allowed me to examine past experiences in depth to explore how women negotiated their social location of the “other” in these historically predominantly male dominated fields. Oral history provides a “big picture” view, in this case of the respondent’s professional life. I analyzed the interview transcripts to study the respondent’s answers regarding personal and professional interactions as well as the explanations given by these women of their personal reactions to challenges and obstacles in order to better understand their negotiation of self and environment. Human subject’s approval was acquired before the beginning of the study.

This study was conducted at the University of Kansas Medical Center in the summer of 2013 for the Senior Women Oral History Project initiated and conceptualized by Dr. Sue Pingleton, MD. Out of 196 tenured professors in the School of Medicine, thirty in 2013 were women. All thirty were contacted for interviews but four declined. One woman who declined was emerita and one woman who declined had left to go to another institution. It is not clear why the other two women declined. Of those interviewed, fifteen were medical doctors and eleven were basic scientists (neurologists, psychologists, microbiologists, etc.) holding a PhD. The range of senior tenured women in the School of Medicine departments, nationally, ranged from .04 to 1 percent in 2012 (AAMC 2012). A large percentage of the women I interviewed (62%) were in “traditionally masculine” subspecialties, giving the impression that at this particular medical school, these women had successfully managed their achievement of rank in a male dominated environment. The women were chosen for the study based on senior faculty status, i.e. all the women interviewed are full professors tenured in their departments. Some women were newly (recent to five years) tenured while some women were emerita status.

Data Collection

I contacted each woman or her assistant directly by phone or email to set up the interview. At the beginning of each interview, the participant was given the consent form that stated that they knew of their rights in the non-anonymous study and that they could remove themselves from participation at any time. The interviews were video- and audio-taped, and so in the beginning of each interview the participant was fitted with a microphone and instructed on the videotaping process. One possible confounding effect of this particular interview process is that because the women were video-taped and identity was not guaranteed to be completely anonymous, answers to the questions might have been less candid than an interview conducted with complete anonymity. The duration of each interview was 60-120 minutes, with a median length of 1 hour and 27 minutes. The interview location was the campus of the University of Kansas Medical Center in Kansas City, KS in the months of June and July 2013. Interviews were transcribed verbatim within two weeks of the interviews taking place. Pseudonyms are used in the women's responses in order to protect confidentiality.

A semi-structured interview guide was used to ensure that participants' responses could be explored more in depth while still gathering a full oral history. They were asked questions about their specialty and background, information for young women professionals such as mentoring and navigating professional challenges, the landscape of medicine when they began their careers, their experiences with and their feelings about part time work, leadership development and experiences as a woman professional and looking back on career and personal decisions (see Appendix). Because I interviewed both medical doctors and basic scientists, the questions asked on the interview guide were written to allow me to tailor the questions depending on the respondent's degree. For example, basic scientists do not usually see

patients, so those questions were skipped. Probe questions were used if a respondent did not bring up a particular experience that other women had mentioned. I found my respondents to answer quite frankly if they did not encounter something in their experiences.

Reflexivity of the researcher

Lastly, it's important to acknowledge the way in which myself as the researcher might have influenced these women's responses. All of the women knew that I was a graduate student of sociology at the time of the interview. The women studied are highly intelligent, and perhaps their responses were tailored, so to speak, to resist or submit to what they perceived as my intentions in the interview. The fact that I was a woman interviewing them must also be noted in that their answers surely might have been different or less candid if I had been a man interviewing them. I also might have viewed their answers differently had I been of a different race, class, or gender. While not all of the women knew that I am a mother (I always answered truthfully when asked) some of them did ask and thus their comfort with problematizing or focusing on the aspect of balancing work and family might have been strengthened. Additionally, the women were all my elders, highly accomplished women, and 'studying up' in this way must be noted for its own, arguably interesting, confounding effects based on the researcher's interview style and practice (Plesner 2011). How power and privilege are perceived and also utilized in the interview process is affected by race, class, gender, education, and social status.

Data Analysis

I used a grounded approach that was developed by Glaser and Strauss to analyze the data of interview transcriptions, interview summaries, and memos (1967). The interviews were coded

by going through the interviews once to see the major themes that developed in the first read through. The grounded theory approach was used for practical reasons as well. When the opportunity for the research project was presented to me, I had a sense that the data would contain many possible research trajectories and projects. With a grounded theory approach, I was able to see the most salient themes to address from the data instead of forcing the data into a pre conceptualized project. In a sense, this allows the researcher to see what is actually there instead of what the researcher wants to see (Dunne 2011). After initially going through the interviews once for the most salient themes, and writing memos about these themes, a second analysis was performed using QSR Nvivo9, a qualitative software program, to organize and analyze the interview data specifically around the foremost emerging themes.

This grounded theory approach allowed me to see main themes to explore in a literature search of those topics (Dunne 2011). The role of the literature review in grounded theory is to search for literature to see if the themes found in a grounded analysis do in fact exist in extant literature. After the extensive literature review was conducted and the applicable works synthesized, the theoretical approach to understanding the experiences of these women was to analyze their presentation of self (Goffman1959) and negotiation of the historically male dominated fields of academic medicine and basic science to understand how these women managed their success. Particularly in the context of this paper, presentation of self is the way in which an individual will attempt to control or guide the impression that is conveyed to other people. How presentation of self and environment are negotiated by women depends on the ways in which they perceive their environment as hostile or friendly to their entrance into the social setting.

Findings

With this research, I sought to answer two questions: 1) what are the experiences of female academic medical and basic sciences professors in a male dominated environment? And 2) what strategies did they enact in order to manage their success in the male dominated environment? Many of the women I interviewed, when asked if there was equality between the sexes in their fields and specialties would respond to me that now there is parity of fifty percent women to men in medical and graduate schools. This statement assumes that equality has been achieved. However, while it is pleasing to know that women have achieved equity in medical and graduate school *admissions*, they are still not achieving parity at the senior levels. If women are still seen as the “other” to the archetype of male physician and scientist, they will need to negotiate these settings in order to achieve rank. By analyzing these interviews, I seek to understand how these women accomplished this through their own efforts and experiences.

I found three main themes of women being cast as an “other” (or different) in their experiences. These were experiences of isolation and exclusion, sexual harassment or sex discrimination, and the need to perform the second shift, or extra family responsibilities. The two ways that I found these women to negotiate being an “other” were explanations for success and strategies of negotiation between self and environment for success. The quotes I use in the following report are representative of the main themes found throughout the transcriptions.

Being the Other:

The first question that guided this research is: what are the experiences of female academic medical and basic sciences professors in a male dominated environment? Women experienced isolation and exclusion, most strikingly through the negotiation of the “boy’s club” and the need for conformity in the environment (and lack of male trust), sexual harassment and sexism, and extra work in family and home matters (the second shift).

Isolation and Exclusion

The women in my study were all smart and successful women, but the professor emerita were the most adamant about how they had entered a very male dominated field at the beginning of their schooling and careers. I encountered no better quote to illustrate this than one from a scientist who is now emerita. She explained to me that she had been the very first woman to be “raised up” at the medical center, as in, she was brought in as an associate professor and received full, tenured professorship at the same institution. But even though she was a charismatic and energetic professor and scientist, she was still a woman, and thus this factor could have been problematic in her ability to achieve rank. However, she told me that when she realized that her promotion and tenure committee were all men, she stopped a male colleague who was a member of that committee in the halls to bring attention to the fact that, as a woman, she was going to be evaluated by an all-male committee. His response was provocative and telling: “Oh Dr. Antonio! We don’t consider you a woman! We just consider you a force to be reckoned with!” While the remark is meant to be a compliment, it says something else...you are not a woman, you are powerful. Women are not powerful.

The Boys Club

Although some women did notice their outsider status, they were also keenly aware of the fact that they had entered a new realm of acceptance when in leadership positions, what they termed “The Boys Club”. Many women spoke to me of the need to “show up” and represent women because they, as senior faculty women, were now part of this powerful “club”. Women from all cohorts, from professor emerita to recently tenured women expressed to me the staying power of this elite network. One woman specifically, when I asked her how she had developed her leadership skills said, “I think, to some extent, by affiliating myself with powerful men.” However, the women who were most likely to acknowledge how they had been included in the boy’s club were the women more likely to be keenly aware of their difference as women. Here, a pediatrician who began medical school in 1978 and also experienced sexual harassment explained just how powerful the boys club can be when I asked if she had ever expressed an idea at a meeting that had been ignored:

Dr. Long, Pediatrician: Oh yeah that’s the true. If the men talk about it and think it’s a good idea, then you’re more likely to get it done. And that’s ok. You gotta work within the system.

Interviewer: I hadn’t heard that one before, that that’s something that...

Dr. Long, Pediatrician: Oh yeah, absolutely. Yeah you have to know where the power lies and figure out how to use that power to your advantage. And you can do that. So if you have a really great idea and you don’t have the support of your male colleagues, it will not go.

Interviewer: What about the support of your female colleagues?

Dr. Long, Pediatrician: It still probably won’t go.

This is a powerful statement. This female medical academic is saying that *even today*, without the support of male colleagues, a woman will have difficulty (or even the non-possibility) of getting her ideas to the table. Even though most women would say that they felt like they were supported and welcomed in their departments, there were still nuanced differences in how they were treated.

And then there are instances where women were expected to do things that they expressed to me that they could not deny doing, as in, they did them not necessarily of their own free will but because of the constraints they felt based on gender. For example, a professor told me that there have been times where she has been the only woman professor in a faculty of twenty professors in the department, and there have never been more than three. One of the problems that she encountered based on her status as a woman basic science academic is that she said, “There have been a couple of little incidences where, you know, I can think of one where there were some changes that needed to be made in my department, they weren’t exactly...somebody was going to end up in an unfavorable situation. A couple of men were asked if they would do it, and then I was told that I was doing it.” This might seem like a small slight, to be told instead of asked to do something that would create hostility in the department. She was seen as an outsider (and was denied the respect of being asked instead of told to do something), and was also given something to do in a way that made it disadvantageous to say no. This is a clear indication that being a woman can mean being treated different than the men.

Another example of this is the pressure to represent all women when in a privileged position, and this was certainly not lost on some of my interviewees. An orthopedic surgeon who was the first woman in her residency program in 1988 explains how she’s felt about being a woman pioneer:

Dr. Feltner, Orthopedic Oncology and Surgery: As far as moments of growth I think a lot of things that I've done I've done not so much because I wanted them for me or for my career, but I understand the kind of position that I'm in and that I'm in a position where there aren't a lot of women and that there aren't a lot of us to break the glass ceiling, to eliminate the glass ceiling, and so if I'm in a position to do that I will. So a lot of things I do, I mean I'm glad they're on my C.V but the main reason of doing it is for the people coming up behind me. So they can't get the same messages that I got, that no woman's ever done this, ergo no women ever will do this. And so I'm now full professor with tenure, I'm only the 14th woman in orthopedics in the country ever to become a full professor with tenure. I mean it's nice to have the title but that was something that I was aiming for at the very beginning, because when I started, and really started pushing things for promotion I think at that point there were only four women.

She was very aware of her status as an “other” and her responsibility to be a role model for future women. Thus, clearly women in my study were and still are experiencing the academy as a gendered space. She goes on to explain more succinctly what kind of responsibility she carries as a woman:

Dr. Feltner, Orthopedic Oncology and Surgery: In my community if you as a woman are asked to do something, it's challenging to say no because then you're only four percent of the people in orthopedics. If you say no, statistically if they're going to ask someone else, the next person they ask is going to be a man because that's what everybody else is. And there's always, there's sort of this subtle backlash at times that if she said no, then that probably means that other women would say no. So we're going to be a little reticent to ask another woman. When I get asked to do something, it's always stuff that I end up enjoying and I like the projects, but I never say no because I'm always afraid of what the implications are going to be for me down the road.

This professor is expressing the understanding of the weight that is placed on her shoulders, and the responsibility to women down the road who may be kept out because they are women. Thus we can see how being the other can affect the lives of women working in male dominated fields; extra work might be undertaken in order to show that women can exist in these spaces too.

In academia, colleague collaboration is arguably a large part of a scientist's success. Working on grants, papers, and in labs can benefit a scientist's reputation and impact the trajectory of their work. Yet a woman scientist in my sample who attended graduate school in 1983 had this to say about collaboration between men and women in the basic science academy:

Dr. Simpson, Microbiology:...there are definitely differences in the field. There's less, people might say I'm wrong but male faculty don't tend to want to interact on a collaborative basis nearly as often with female faculty as male faculty. And I've heard this from people at other institutions that you know, that's very difficult. It's very difficult to get that very trustworthy solid collaboration going with male faculty for some reason. But I have great colleagues who are males and you know, if a project comes up, definitely, and I do collaborate with them, so it's not always that way. But I've heard that complaint, and I've sort of seen a lot of times that even though I know that I have that expertise or even better expertise that I'm not the one who's being consulted on certain kinds of projects

Once again, this female scientist said that this is something that is problematic today, not just in the past. Women are excluded from key networks and are still encountering difficulties given their experiences of exclusion to manage their success in the male dominated environment.

Sexual Harassment and Sexism

Women in my sample reported that men who were in authority over them had made sexual comments or gender and or sex discriminating remarks to them. Some women would tell me about experiences in the past while other women acknowledged more recent experiences. A pediatrician who started medical school in 1978 explained to me that she had been told by her surgery rotation resident that if she did not sleep with him she would not receive a superior (a high mark for the rotation). When she went to tell the Chairman of the department about it, he told her that the resident has just been kidding. She knew that sexual

harassment was not taken seriously and had another incident occurred, there would be no point in bringing it up with anyone in authority. Another woman, an oncologist that began her residency in 1974 told me how sexual harassment was used by men as a way to call attention to her gender:

Dr. Bailey, Oncologist: ...one of my memories is as a female medical student, the only female medical student currently on that gyn rotation, ob gyn, which was all male faculty. And the professor who was the chair was pretty dynamic and flamboyant and expected everyone to watch him operate when he operated. So whether you were his medical student or not, when you're on obgyn you came, everyone came to the OR to watch him operate. Women were not allowed to wear pants on the wards, when you were on his service. You had to wear a skirt. And you know, nobody said, I don't have to follow that rule, we followed the rule. And so you had to wear a skirt (in the OR) and we had greens. Well they were dresses...so I wore a small but I got there and all the smalls were gone. But I was not going to be late. So I put a medium on. And that medium came down below my knee. And in the middle of the OR, or in front of the whole OR. He called me out that my skirt was too long. And to go back and find a shorter skirt.

Sexual harassment and sexism are undoubtedly powerful tools for keeping women in their place and threatening them by means of abuse and exclusion. With sexual harassment and sexism, men are able to either subtly or overtly remind women that they are different, less powerful than men, and can be threatened with adverse status if they are to speak up about their experiences. No matter when it happened, it was apparent that women understood that these ways of interacting with men created an environment in which they were seen as encroaching on male territory.

Second Shift

The women I interviewed explained to me that women are still struggling with work life balance. In response to my question of what has changed in academic medicine and what has stayed the same, some women pointed to the constrictions women still face when trying to

balance work and family. A clinical pediatric psychologist who started graduate school in 1985 said, "...a lot of that stuff still falls to women... It'd be nice to see a time when it's 50/50. So even though we have dads who are more involved, they're still not doing at least in a lot of families, certain things are still falling to the moms. So we need to figure out a better way to support that." A medical doctor echoed a similar sentiment, but cited individual solutions as the cure. Dr. Evans, who started medical school in pediatrics in 1968 said, "I think the similar; the big overriding similar issue is that women are still primarily responsible for their families. And you have to figure out how to do that and the solution generally is an individual solution." But the overarching theme of the expectation that a woman should work hard above all else despite family constraints was seen in the response of a medical doctor who started school in 1971:

Interviewer: Do you see your female students struggling to negotiate the work/family balance more than your male students?

Dr. Kucher, Family Medicine: I think that's always been the case. When you talk to young women it's the same. Men have grown up seeing men in the workforce. I think men probably struggle more than they used to. I think a lot of them now feel like they want to be home more with their kids. But I think women still struggle more with that. We need to figure out the whole child care thing. It's a big problem. Because if you look at organizations that have child care on site, there are lot of organizations that literally have child care on site, so you bring your child to work, you put them in child care at work, you can go have lunch with your child, you can nurse, you can see how they're doing, and then you can go, your kids are close, you don't have to worry about it. I went through nursing by you know, I brought my kids for a while but then I had someone close and I would go at lunch, to nurse. And you park, where you park is 100 miles away so you run to your car and you nurse and you come back and you know, and you try to fit it in, or you know your clinic runs late and you're going ahhh! It's time to nurse and the baby sitter's calling "should I give him a bottle or are you coming?" so there's a lot of, it's hard! Guys don't do that! They just come to work and they work. So figuring that out, and making it so you can actually work and know that your kids are well taken care of, you know, that makes a huge amount of difference.

These examples in particular show that women are structurally constrained by the role of women in public and private spheres. Yet they explained in other parts of the interview that working hard was the best avenue to managing success for women in medical and basic science academia. If one works hard and makes all the right choices, things will work out for them. A neurologist who began medical school in 1980 had this to say:

Dr. Wheeler, Neurology: We're slowly getting there. Some of this has always been, there are fewer women...as there are more women coming up through the ranks, more women with positions of power, and it's been very slow but of course one of the problems is that you know, you're not going to get into, be in a position of power if you're not putting as much effort into something you know, you can't work part time and be dean. *You have to make the choice at some point as to how much time you're going to put into something.* Um and I don't know how to change that because I don't think I necessarily want people to work less hard to obtain goals. *I think that we need to give people the right to do what they want to do and not worry so much about the gender equality thing* (my emphasis added).

These examples show how women are constrained yet explain their success in terms of hard work and meritocracy. This type of strategy to manage success makes sense, especially in academics, where people are expected to produce valuable research and effort for the university. It is generally agreed upon that one should work hard to enjoy the success that is necessary to achieve rank as a senior tenured professor.

Explaining Success and Negotiation Self and Environment

The second research question that guided this research was: what strategies did they enact in order to manage their success in the male dominated environment? I found that women explained their experiences of success with a narrative of the "exceptional woman" and meritocracy. Strategies of negotiation included constructing themselves as being easy-going

and with a carefully constructed femininity. Other explanations and strategies emerged but these were the most salient themes that I saw in multiple women's narratives.

Exceptional Women

Some women, when asked how they were treated by others in medical and graduate school, said that they were top of their class, for example, as if that would be evidence for why there was less discrimination toward them (or noticed by them). This brought to mind the "exceptional woman" as she who is unlike other women (and thus, more like men).

Women would tell me that they gained academic achievements by being the best students, doctors, and researchers that they could be (which is related to meritocracy). Some women even considered the questions in the interview that were specifically about gender to be "looking for something" or unnecessarily tailored to gender. For example, a gerontologist who graduated medical school in 1980 had this to say:

Interviewer: Do you see any persistent gender biases?

Dr. Myer, Internal Medicine: I really don't see much. I mean I guess that's what I'm not sure the purpose of the interview is, um, I don't feel that there were a lot of biases that I could detect. I'm sure there were implicit biases and implicit messages, and I'm not questioning that they were there, but I received from my view very fair treatment as a medical student, I graduated at the top of my class, I didn't run into anybody who stopped me from doing anything that I was willing to work hard enough to do. And I don't feel like there were gendered themes almost anywhere, with the exception of maybe the oldest male physicians, and I was the youngest student, who seemed puzzled by it. Um but as far as direct lost opportunities go, and I'm sure that's because a lot of the people went before and did a lot of that hard work. But I have some trepidation about making gender a theme in an era where in a field where, half the medical students are women, half the internists are women, half the, our residency class is half women, and *I think we can twist it into something it shouldn't be if we get too focused on gender* (my emphasis added).

While this respondent expressed the strongest reaction against considering gender in the experiences of medical and basic scientists, she was not the only one to couch this kind of sentiment in this type of way. Other women also expressed their concern or disagreement with “looking for” gender, and some of my respondents would adamantly say that they do not look at things “in this way.” This kind of attitude creates a double bind for other women. It implies that women who do experience gender discrimination do so only because they are not as smart, savvy, or successful. This kind of statement could be perceived as a way in which to ignore gender and the effects of gender on advancement in academia. There are structural elements to why women do not succeed, but these kinds of statements erase them and place the blame on the individual. In essence, this reiterates for women that “any problems you have are your own.” But if we would like to think that this sort of challenge for women in leadership and privileged positions is a thing of the past and gender is no longer a problem, we only have to heed what the doctor who started medical school in 1978 said about this problem that carries on today:

Dr. Long, Pediatrician: Women need to be in leadership positions. There are women who are capable who are passed over for whatever reason, I don’t know. So more women need to be in leadership to help create more women leaders. You can’t create women leaders if you don’t have good role models. And for whatever reason, and I don’t understand the ceiling that we have in academic medicine. So I think we have to move this along somehow, it almost seems like affirmative action, but in some way it’s...I mean if we’re fifty percent of the medical school class, there should be 50 percent of women in the leadership roles.

So, there are women who are capable academics and strong leaders who do not achieve rank. Not all of my participants would deny that gender was a problem in the experiences of women, but many would. That’s why I termed this a strategy of “exceptionality” as a way to ignore gender bias. This strategy is directly tied into the way in which I found women explained their experiences as senior women as the result of hard work and merit rewards.

Meritocracy

One way in which these women enacted the meritocracy code was to remind themselves and others that women are not here to make excuses (about gender) and that hard work was what got women to the top. Many women said variations of this when I asked them what advice they had for women coming up in their specialties or fields. The question I asked was specifically tied to how to mentor young women in the field, but the women respondents would often say: work hard and you shall reap the benefits. This ties into how women would also couch obstacles to success or an inability to progress in rank as something because of personal choices, personality, lack of inherent ability, and drive (but never because of gender). Success, one woman told me, was in “how you put things together.” Many women, when I explicitly asked if they’ve seen gendered patterns or differences in their students or colleagues would respond with something along the lines of “maybe, I don’t know, I’m not looking for it, I try to ignore that stuff.” So even though they may have been aware of a pattern, or possibly willing to acknowledge that there was some troubling stuff going on in their experiences, they wanted to just put their heads down and work. They didn’t want to acknowledge there are still patterns of bias and privilege.

Managing Success through Negotiation of the Interaction

Being Easy-Going

Some of the women that I interviewed explained to me that they were easy-going. When I asked them about gender bias or discrimination that they had encountered or seen, they told me that this was not the type of thing that they noticed, or that if they did, it didn’t matter much to them because they just don’t let things like that bother them. Even though

many women presented to me the undercurrent of meritocracy as the reason for success in medical or basic science academics, they would then also acknowledge that they had been or were aware of the gender hierarchy of male dominance, backlash against women, or unequal distribution of resources. But they often explained away these contradictions with responses like “I’m easy-going” or “I don’t really notice that stuff.” An otolaryngologist who began graduate school in 1978 explained her tokenism in the group in this way:

Dr. Hurley, Otolaryngology: But even now I mean it’s not unusual that I am one of the only women in a group of men, so among the modules directors for example in the medical school there are only two of us who are women the rest are all men. Um and I you know, after a while you just, you know, *that’s just the way it is and you just don’t worry too much about it* (my emphasis added).

One of the questions in the interview was about experiences the respondent had had with those who were to address her as an authority such as students or residents. Most of the women I interviewed stated that students were more likely to call a woman doctor by her first name and a male doctor by his title. Almost all of the women would explain that this meant very little to them and that they did not mind being called by their first names.

Dr. Fox, Psychology: I’ve not found that, you know I’m so easy going that I think they just kind of, they come up and they want to know about that, and they all refer to me as (first name), except for the newer ones, and they all refer to me as Dr. xxx. And I don’t care how they refer to me that really doesn’t bother me.

This strategy of being easy-going extended to all kinds of experiences, including sexual harassment. This medical doctor had told me how she had experienced sexual harassment in medical school, residency, and even in her clinic:

Dr. Kucher, Family Medicine: You know it didn’t bother me you know a lot because I was so used to it. When you look back and you see some of the stuff and think, man that was, you know, I would not want other women to have to be in that position. But it didn’t bother me that much. And a lot of times I would just kind of blow it off.

Many of the women that I interviewed spoke to me about how academia works. There are certain tasks to be done and goals to be met. However, added to the regular academic work an academic physician must do is the work of being a clinician and making choices that affect people. This type of life or death job does create stress when you are dealing with people's health and well-being. When I asked a medical doctor who attended school in the 1970s how she worked to build her credibility and visibility as a woman professional, she expressed the keen sense of how in precarious situations (fast paced, health crisis) individuals desire conformity.

Dr. Braun, Pulmonary: "Now, do you have to earn it a different way, perhaps, than the male counterpart? Less than you used to, but you still have to a little bit I think. But I don't know that anything is unreachable for (medical) academics. I really think I might be a little more savvy about it. Yeah there's an old school, but that's because people are comfortable, right, and everything else is always so uncomfortable in work, often times, non academics, it's chaos with funding and healthcare and all this stuff."

Being an "other" is frustrating, yet this medical doctor negotiated this frustration by explaining it away with *those things happened in the past*, even though it was happening to her in that moment, in her training. This exchange is describing how she was treated as a chief resident with the other two male chief residents:

Dr. Braun, Pulmonary: "And [the male chair of medicine] would sit there, who I consider had been a mentor to me, but he would talk and he would always look at the other two guys, well, who, you know, do we have enough to fill that and what lowers the budget and all of a sudden he'd look at me and he'd go well Amy! How are you! And I'd just go, really?"

Interviewer: You were an other.

Dr. Braun, Pulmonary: “Yeah, I was an add on. So, and he was old school, old school Boston trained so I, that gave me a good view of *what it used to be like for everybody*, I mean gender wise.” (my emphasis added)

This quote demonstrates that even when women achieve leadership positions (in this case being one of three chief residents) they may not be fully integrated but maintain some “other” status. However, this same doctor developed strategies and self-presentations to deal with being a woman entering a male dominated field. Other women in my sample expressed similar strategies (which I explain in more detail later as “easy-going”). This makes sense if we understand how women need to be able to both explain and deny how gender works to refuse them conformity in the institution.

Interviewer: How did you practically work against a situation like that where you were an add on, to build your credibility and visibility as a woman professional?

Dr. Braun, pulmonary: You know I used humor. Oh it took a while. Not the first couple months for sure. But the, you know, once you, I don’t recommend humor right away for most folks because you may think it’s funny and someone else doesn’t, but I do think humor, once you’ve established a little bit of a rapport with the individual, that you can use humor, you know...pretty soon he knew I knew, and this was really just pointing that out that hey, over here, seriously. And it really worked out very well.

This doctor was able to create a strategy of dealing with being ignored in the meetings with her chair, even as a chief resident, by challenging the chair of the department in a non-threatening way, with humor. Women would not need to negotiate in these savvy ways if they were fully integrated and not seen as different. Women must find a way to become trusted and part of the male conformed group in order to manage their success.

Women must also have an awareness of how they are perceived in an interaction, and how they must deal with contentious situations. At one point, a psychiatrist who

began medical school in 1974 explicitly related her experience to how women walk a tight line between getting respect for their work or being ousted for bringing too much attention to the structure of exclusion. She had argued for over ten years for a certain scientific argument regarding compliance of patients, but had been repeatedly ignored. Then, after ten years of her arguing her stance, it was found by male researchers that her argument was valid.

Dr. Jung, Psychiatry: “Now do I crow and say I told you so? Do I quietly... but the question becomes, you know, how do you manage in situations where somebody has discounted what you said, possibly because you’re female, possibly because in my setting, Kansas City is not a big research generator. And I don’t have a lot of professional accreditation whatever you want to call that. But then how do you go about saying, yeah I did know what I was talking about and you didn’t. I think women have to be very careful with that. It is difficult in any kind of setting, but for a woman to have had a major criticism against a hierarchy or a structure that is predominately male and then turn out to be correct, I think you have to be really careful about how you proceed from there. Otherwise there’s a possibility of being shunned.”

The incident this woman is describing did not happen in the past—it was recently. Much of the argument heard about women in academics or women in professional realms is that gender hostility such as this is historical. However, it simply is not true. This was also what was meant when women identified the “good old boys” club, or network of powerful men, and could account for the reasons women who *did* work hard didn’t make it to the advanced ranks.

Carefully Constructed Femininity

I saw how women were aware of their need to carefully construct their femininity as women in order not to be seen as too aggressive or too weak. Women are certainly held to a different “code” in their interactions with colleagues. Here, a clinical psychologist who began graduate school in 1958 explains:

Dr. Becker, Clinical Psychology:...women can say exactly the same thing and in exactly the same tone, exactly the same cadence as a man and a woman will be considered a bitch. Or that she grumpy, or not nice. A man can, that's just kind of part of being a man. So I think that there's a different dance that you have to do in order to be seen as a leader. Um, it's a very hard dance to teach. And I don't know if you teach it, what happens is a woman may react in a certain way and then you go to that woman and you say, "you know, I think that wasn't the best way to handle that, you know, you're being perceived as, you know", but the last time something like that happened it did no good whatsoever! And so, I don't know whether you can teach (a woman to handle a situation without being labeled a bitch), I don't know. I think they have to watch it, I think they have to feel comfortable in themselves and I think they have to just be themselves. I don't think you can compete with being manly, anyway. But I think you have to be...you have to know kinda who you are and what you believe in."

And a pulmonary clinician who started medical school in 1968:

Dr. Healey, Pulmonary: I think my generation, and I can only speak from my generation, I cannot speak for the younger generation, I can observe, but I can't speak for them. So my generation I think we walked a delicate line between being feminine and oh the opposite of feminine is unfeminine. And maybe a little bit more held back because the opposite of kind of holding yourself back is being aggressive! So it was a very delicate dance.

Interviewer: So you're saying aggression was not equated with femininity.

Dr. Healey, Pulmonary: That's exactly right.

Interviewer: So you ran the risk...

Dr. Healey, Pulmonary: yes, of being seen as aggressive. Bitchy.

Interviewer: What were the implications if you were seen that way, what happened?

Dr. Healey, Pulmonary: Oh it was negative, it was pejorative. It didn't help in your career, if that was your persona. So it was a very delicate dance. My observation is that it is not quite so much (now), but I think it's still there.

Here we have explained the kind of tension that being a woman in this situation will create, and not only that, but the delicacy in which a woman must operate (what I've termed savviness throughout this paper). The clinical psychologist even goes as far as to say that it's almost impossible to teach or mentor another woman how to negotiate in these ways, as it is not something that is overt, but subtle.

Women are then too aggressive if they speak out of turn, but confounding to others if they don't act feminine in expected ways. In an interesting example, an orthopedic surgeon attempted to manage her interaction in a surprising way: by not smiling. Here she explains how it went:

Dr. Feltner, Orthopedic Oncology and Surgery: ...society expects women to smile all the time. And they think that if we smile then it means that we're in agreement. And not understanding that women's body language, that if we smile it just means that we're listening, it doesn't mean we agree or not. If you're in a tough negotiation the best is not to smile. Because then people can't, they have no idea what you're thinking. So yes I was involved in a negotiation that I, I sat through the entire negotiation, the two-there was a gentleman that was with me and a few men that were on the other side negotiating and I didn't smile the entire two hours of the discussion.

In this example, she negotiated both her presentation of self in a non-feminine way and negotiated terms of a deal with all male colleagues. This type of awareness is underestimated, but the women in this study all show how being aware of their gender status as women created a need for them to interact with others in careful and calculated ways.

A different, but compelling strategy complimentary of being "easy-going" that I found in my respondent's answers was the carefully constructed femininity (or even the almost absence of femininity) in order not to appear as an "other" encroaching on male dominated space. A professor that was in a highly male dominated department was the most overt in her description of managing conformity with a non-feminine presentation of self.

Dr. Snow, Neuropharmacology: You know, the things that I tried to be careful with, I was always conscious of being sure that I was taken seriously. And so that sort of meant not doing girly things. And particularly, most of the men I work with, none of the men had wives who were scientists. They may have had other careers but they did other things. And so there were things that you know, making sure that you didn't get, you

know I never felt like I could be friends with their spouses. And I was always careful not to be friends with, not to be aligned too much with other women. So there were my colleague's wives, the secretarial staff, you know, I've always felt like I couldn't be too friendly with them. Because then I'd be part of the, you know, *this other tier of people* who weren't, you know. Or not dressing up too much. Not being the hostess. And it was very, sometimes you'd get saddled with being the department hostess.

Interviewer: What prompted you to actively construct yourself in these ways? Did you see something? Did you hear something? Or did you just think to yourself, this is probably the best road to take.

Dr. Snow, Neuropharmacology: I think it's more, you know, it was clear that most of my male colleagues viewed these people as not us. And so it was, you know, it seemed that the best course was to not set myself up in a way to be part of one of those groups that would lead to my being marginalized, being viewed as a lightweight.

While another woman in this same department of the university did not echo this sentiment, it's clear from this scientist's responses that she did not simply manifest a hyper vigilance to the way that she was perceived out of paranoia. And it's important to note that the kind of activities this professor was avoiding (hostess type duties) would have been tasks that do not contribute to promotion and tenure. Thus, this kind of response shows a decidedly savvy observance of departmental culture and norms, as well as the ways in which women might be waylaid on their path toward rank. The difference found in her response and the other women in the same department might be explained by the degree of success that each scientist felt could be achieved with each strategy. While one scientist opted for a downplaying of her femininity, the other scientist did not feel the need to downplay her femininity in order to manage success. But the fact that they each chose their presentation of self illustrates that these professional women make choices on how to negotiate the setting.

Discussion

This research shows how women have negotiated self and environment, specifically in an academic medicine and basic science environment, based on Kanter's (1977) and Acker's (1990)

theories of the gendered organization. I argue that women in the historically male dominated fields of academic medicine and basic science experienced isolation and exclusion, sexual harassment and discrimination, and the second shift because they were seen as different entering a previously male dominated space. These women managed their success in that they had “played the game” and thus negotiated self and environment in order to appear non-threatening to male incumbents.

Being the Other

One of the ways that women in the medical and basic science academy experience difference based on gender is the lack of representation of women in the higher ranks of the academy. This can result in limiting the role models for women that wish to rise up in the university leadership ranks. This issue is admittedly complex, as there are many ways in which women perceive the academy to be a hostile environment. Women often receive less salary than their male counterparts (Ash et. al 2004; Carr et al. 1993; Kaplan et al. 1996) and they are more often negatively impacted by their roles in child and family duties (Levine et. al 2011; Speck et. al 2012). These and other factors will contribute to their skewed advancement in the academy. Thus, with the ratios of tenured men higher than tenured women, the message given to women medical and graduate students is that it is more difficult to attain a tenured position for women. The women I spoke with did acknowledge that it was still difficult for women to negotiate what is called the “work life balance,” as well as pay, and that solutions needed to be found for this double standard.

One aspect of the interviews with my participants that I found surprising was that they would not only acknowledge how women had trouble negotiating the work life balance, but

increasingly they were seeing that their male colleagues and students were having trouble negotiating this aspect of professionalization. However, if this is true, why are women still not advancing to senior rank in parity with men? There is arguably something different about being a woman negotiating work life balance and a man trying to do so. I argue that women still battle their “otherness” in countless other ways than just the added role of being primary caregiver or second shift duties. A qualitative research paper on female medical academics reported that women expressed a preference to be mentored by other women (Bickel 1995). However, if women cannot move up into leadership positions, they are unable to mentor junior academics. Thus it can be argued that non-conformity issues in an institution do adversely affect women, whether the women (and men) are aware of them or not. The confounding effects of sexism, representation, the need to negotiate work life balance and salary, all create an environment in which women need strategies to manage their success.

While some of the women that I interviewed expressed that they did not think that sexual harassment was still as big of a problem as it had been in the past, recent studies have shown that women are still reporting sexual harassment in their experiences in medical school (Babaria et. Al 2012). However, some of the women did acknowledge that one of the first ways that women in this study were reminded of their gendered status was being made the other by sexual harassment. In a previous study on gender discrimination in medical school, both women and men perceived gender discrimination experiences to be higher in specialties such as surgery and obstetrics-gynecology. Research reported that the specialties in which women were least likely to experience gender discrimination and sexual harassment were pediatrics, family medicine, and psychiatry (Nora et. al 2002). However, my results did not conform to the trend seen in that paper: women in pediatrics, oncology, and family medicine

expressed having sexual harassment experiences in their medical school training and beyond, and I found that they expressed having these experiences on par with surgery or other male dominated subspecialties. Also, Hinze (2004) found that women were reluctant to bring up their experiences with sexual harassment for fear of seeming like they were over sensitive or weak. Women in her study considered sexual harassment to be a part of medical school socialization, and showing that one can handle it keeps one from being stigmatized. Sexual harassment is thus still prevalent in women's experiences in the various subspecialties, and can thus lead to their need to strategize ways in which to negotiate self and environment.

Explanations for Success

These narratives demonstrate a complex ambivalence regarding the impact of gender on career. What I found interesting was how these women would explain both gender disadvantage (most often colloquially called the "old boys club") and their insistence that they had not seen or experienced gender disadvantage in the same interview. I termed these explanations of gender disadvantage as being an "exceptional woman", and working hard in the meritocracy. Strategies women showed for managing success were being "easy-going" and constructing a careful femininity. Once I began to explore the tensions between being an "other" but explaining away gender disadvantage with earning rank by merit, I argue that the theory of Belief in a Just World can help us understand why women enacted these particular strategies when faced with their tokenized role as women others.

The women in my study realized that, as women, they were an "other" in a male dominated space and thus needed to prevail against all odds. By explaining how they were exceptional, worked hard, created their success with their own merit, and were easy-going, they

were illustrating for me how they managed their success. Everything they told me that contributed to their success undoubtedly did. Some women said that they ignored gender bias, while others claimed that they were unaware of such things. I believe every woman's recounting of her experience. The strategies they used were noteworthy because these women were all successful, therefore, any strategy they used worked. However, research has shown that female physicians are expected to not only own and utilize the technical expertise needed to solve the problems of their patients, but are also expected to perform emotional labor and emotional organization as well (because of the way that women are socialized to be mothers). Male physicians were only expected to own and perform technical skill (Brooks 1998).

Strategies of Negotiation

Being an exceptional woman who conforms to the ideal worker image and works hard and is at the top of one's class is a strategy to combat disadvantage, but it is an individual one. Some women still work hard, are still the top of their classes, and do not see the success. Perhaps it takes an amalgamation of all different strategies, some that I did not even have the capacity to catalogue, in order to achieve true success in the academy. The ability of women to ignore the ways in which they are discriminated in a strategy I termed "easy-going" would probably not work for everything. These particular strategies of managing success worked for these particular women. They enacted a savvy negotiation of their presentation of self and environment in order to become successful in their work. However, one theory in particular helps to explain why the women in my study focused on meritocracy vs. disadvantage when explaining their success, and that is Just World Belief theory.

Theory of a Just World: Meritocracy vs. Disadvantage

The utilization of just world theory (Laurin, Fitzsimons and Kay 2011) explains the way women in these institutions respond to their disadvantage by focusing on meritocracy to justify long term investment in possible future rewards. The just world theory was developed by Martin Lerner as a way to understand negative societal experiences. He found that victims were often blamed for their own misfortunes instead of the structural elements that might be at play. Conversely, he conducted a study on systems of rewards and found that when one of two people was chosen at random to receive an award, that person would be more favorably evaluated by observers (Lerner 1980). Thus, this theory has been developed to help understand why those who are disadvantaged will cite rewards as symptomatic of hard work and effort instead of problematizing structural constraints (Laurin, Fitzsimons and Kay 2011). This creates a conversation that centers on meritocracy when we examine how people advance in professional settings. Yet if we specifically examine the role that gender plays in advancement, we can see how women are disadvantaged in institutional processes because of gender inequality.

Acker (1990) states that gender inequalities are built into and somewhat formed by organizational processes, which would explain how the unequal distribution of women and men in higher academe persists. Acker states that the “image of the worker” is masculine and male: men’s bodies are worker’s bodies, because under patriarchy, their bodies do not have the “imperatives of existence” (pg 149) of procreation to contend with. As in, these disembodied (read: male) workers do not have household duties that will interfere with work. The ideal worker, able to devote full time and effort to the job, is code for “male.” Thus

women are disadvantaged in occupational structures because of the gender inequality built into them.

This also explains the way that women are clustered in certain subspecialties in medicine and basic science as well. Women are aware of how their gender affects their experiences in medical and graduate school, and they receive more trouble for their time in male dominated specialties (Zimmerman 2000). Previous research has examined how women assert that compensation is not distributed equally based on credentials (Ash et al. 2004). Additionally, how gendered experiences are handled for women by their supervisors will either encourage or discourage women in their careers (Zimmerman 1995). Women have also reported a lower sense of belonging in the workplace in academic medical and basic science departments, and a failure to feel accepted and supported (Pololi et al. 2012). Research such as this that analyzes the negotiation process between self and environment in medical and basic science departments and how women succeed despite these disadvantages creates a better understanding of the strategies women use when they are either aware or not aware of their role as the “other”. A Just World belief system makes sense given these disadvantages women face and how they must enact this belief system to persist in the medical and basic science academy.

An extension of Acker’s theory of the gendered organization is seen in more recent literature. Williams, Muller, and Kilanski (2012) focus specifically on Acker’s theorization of organizational logic, which is how hierarchies in the organization are rationalized and legitimated. The women in my study were less likely to problematize the structure of the hierarchy, and more likely to consider individual actions and efforts as the cause for success or failure. Acker was the first to argue for these hierarchies to be seen as gender

discriminatory, instead of the gender neutral bureaucracies they are touted as in mainstream culture. This has been shown in other male dominated professional sciences. In Williams, Muller, and Kilanski;s (2012) study of women geoscientists in the oil and gas industries, they found that women were beholden to “gender consequences” by way of the organizational logic of teams, career maps, and networking. Because advancement is based on personal performance, but the geoscientists must work on teams, the supervisors of the teams (usually men) have a heavy hand in each worker’s “career map” (or team placements). This goes hand in hand with networking, in that whomever a woman knows because of her team placement will affect which team she can go to next. Thus, women are still being shut out of the most powerful leadership positions based on the lack of opportunity to become supervisors, affect their own career mapping, and network with the right powerful people (Williams, Muller, and Kilanski 2012). The women in my study did in fact mirror the trends seen in this study, in almost identical ways. Without access to the powerful network (men), women acknowledged that it was difficult to succeed. Another study of undergraduate programs in science and engineering cites gender disparities in organizational structures as a key factor for the lack of integration of women into science (Fox, Sonnert, and Nikiforova 2011). This is a significant piece of gender organization theorization in that it shows that women are still being tied to gender norms and expectancies in contemporary times.

It is easy to see why these women enact a downplaying of their difference through presentations of self, as well as the playing up of meritocracy systems of just rewards, when we examine the stories and experiences of these women en route to a tenured, advanced rank. There is contemporarily and has been historically a “boys club” that keeps women at bay. Acker’s (1990) assertion of the way that organizations are male-typed makes sense in analyses of how the

women in my study constructed themselves in such a way so that they could be aligned with the typical (male) worker in medical and basic science academics.

There is research that attempts to understand and predict the advancement of women in academic medicine. Some of this research has found that although the numbers of women physicians are increasing at all levels of the tenure track (assistant, associate, and full), based on predictions in the study 334 fewer women went from assistant to associate professor than expected based on rank, publication, schooling and specialty, and 44 fewer women went from associate to full professor than expected (Nonnemaker 2000). Another study by Carnes et. al (2008) argues that deeply embedded gender biases and assumptions about women is the reason that women are not advancing to leadership positions in academic medicine. Noteworthy as well are the results of a survey that studied the appointment of women professors in academia: it was found that even prior to appointment, men were shown to convey biased, discriminatory attitudes towards women candidates regarding preference of working with another man. They were also reported as saying that they thought that women are less dedicated to an academic career (Van Den Brink 2011). So it's not surprising that the scientist told me that she had expertise but was sometimes passed over for projects because her colleagues preferred to work with another man. Women in my study also expressed the profound sense that part time work (and dedication to their families) alienated them in relation to their male counterparts.

However, we must also examine how women's agency in gendered organizations is expressed in the small negotiations they make between self and environment within seemingly non-agential circumstances. As in, I argue that women do enact their agency by what I've termed their "savvy" understanding of how they must navigate the male dominated space. Mahmood's (2001) concept of agency is helpful to us here: "Such a conceptualization

of power and subject formation also encourages us to understand agency not simply as a synonym for resistance to relations of domination, but as a capacity for action that specific relations of subordination create and enable” (pg. 210). The women in my study were undoubtedly capable of relating in their savvy negotiations because of their keen understanding of their environment.

Originally, I was surprised when some women became resistant in the interview process, with noticeable tension in their body language, voice intonation, speech pattern, and choice of words, when I would start to ask questions that were explicitly about gender. Upon further analysis of the interview data, I understood why my questions were bothersome. Women seemed wary of saying its “men against women” because that shows aggression and the tenets of the meritocracy is to erase gendered difference and gendered hostility. Women get labeled for their aggression as being abnormal in a number of ways, for instance, by being called bitchy or policed for not conforming to femininity (Frye 1983; Williams, Muller, and Kilansky 2012).

The women in my study also explicitly said that this was the case: women who are too aggressive are ousted. I argue that because these women *were* so careful about their presentation of self and negotiation of the environment (being goal oriented but not *too* pushy, being feminine but not *too* feminine, and being confident but still “easy-going”) they were able to persist in this male dominated male conformed space as a female other. I was actually quite awed by these women and their stories. They were able to persist in an environment that was (for some more than others) difficult and hostile and make it to the advanced ranks and still have productive careers. Previous research such as that by Van Den Brink (2011) and Carnes et. al (2008) have shown that women are stereotyped as less confident, less likely to advance, and less dedicated to their careers. Clearly, this is not the case for these women. Something else contributes to

women's skewed advancement in leadership in academia, and I argue that the structure of the male dominated environment creates difficulty for women who must negotiate self and environment in a male incumbent space.

This problem was illustrated by how much work these women had put into their own presentation of self and negotiation of the setting. I argue that women are still not advancing equally in medical and basic science academics even with higher numbers of graduates because of the role of trust in organizations. Women worked diligently not to appear as the "other" so that they were non-threatening to the male hierarchy so that they may advance to leadership levels. Thus, women have to deny their difference as female in order to advance, which takes a lot of emotional work.

My respondents would acknowledge that other women (or themselves) have a problem with self-promotion, confidence, presentation, and feelings of extreme inadequacy. Other studies have shown the same results of women dealing with self-promotion and feelings of confidence (Blanch et. al 2008; Carr et al. 2003; Ceci, Williams, and Barnett 2009). It's possible that these women were successful because they did not have these problems. The women in my study that enacted Just World beliefs showed me that this thinking paradigm had worked for them: if one is invested in long term rewards, one can't expend too much energy battling the system the whole time. There is something to be said for hard work and dedication, when it looks like keeping low and working hard is what is needed to succeed.

Most of these women may not personally subscribe to the ideal that women and men are inherently complete opposites, yet many have adhered to their socialization that women are

nurturers, collaborators, relationship builders, and part of a team. Studies on perceptions of women doctors have shown that they are perceived in these same ways (Babaria et al. 2012; Floge and Merrill 1986). This kind of carefully constructed femininity downplays their entrance into formally male dominated spaces. These women must not only enact femininity in order to avoid appearing odd, they must also downplay their status as “woman other” so as not to appear as if women are taking over the institution. This sort of tension explains why in these interviews women would switch back and forth from denying gender bias to acknowledging it.

Structural problems are overbearing, immutable, and strong. Members of disadvantaged groups are more likely to believe that people get what they deserve, especially if they are long term orientated. This means, for instance, when a female medical or graduate student is just starting out in her first year of school or training, if she knows that there are structural constraints keeping her from reaching parity at senior levels, she’s likely to want to give up the effort. However, by believing that the system is a meritocracy (instead of a “good old boys” club), someday her hard work may pay off. Yet the structural problems the women I studied faced of isolation and exclusion, sexism and sexual harassment, and difficulty managing both work and family are able to be changed. Women could be supported and mentored instead isolated. Institutions could offer longer family leave and on-site child care (many don’t). The onus should not be placed on women to negotiate a hostile male dominated environment. The environment could be changed to become fully inclusive.

Conclusion

This paper draws on oral history research to examine women’s experiences in the recent past to explore how gendered processes have worked to influence the senior faculty women in academic medicine and basic science at a large Midwestern academic medical center. By

analyzing twenty-six oral histories, this paper contributes to developing knowledge of how female physicians and basic scientists have experienced differences for women that exists in the higher positions of leadership and professorship. The women in this study enacted a presentation of self and negotiation of environment in order to ease the tension between their social locations of “other-as-woman” and “doctor” or “scientist.”

The oral histories in this study describe an academic atmosphere that is challenging and difficult for women. Following Acker’s (1990) theorization of the gendered institution, research that situates women in their socio-historical context is an imperative endeavor if we wish to understand the mechanisms by which women have been and still are exempted from full inclusion in these societal institutions. We must understand not only why and how women are made different in organizations, but what they must do to negotiate their presentation of self and environment in order to manage success in their medical and basic science professions. By understanding the male dominated setting that women are entering, we gain a clearer picture of what challenges women still face in professional organizations. What’s more, the atmosphere is one that is already challenging to any student or faculty, regardless of gender, yet this research shows that women must negotiate their self and environment with a shrewd precision to manage being an “other”. In analyzing these narratives, I argue that women enact a theory of a just world in which to explain their success. I also argue that these women enact agency when faced with discrimination against women. While the women I interviewed do not explicitly say so in such terms, it is not that they cannot articulate it in this way. Rather, I argue that the women studied have mastered the art of savvy navigation of these tensions.

I implore the reader to examine the kind of climate that women are entering into, and explore if it is really changing. Understanding the negotiations women will have to make as

they traverse through the environment is important. Given this climate in academic medicine and basic science, it is necessary to understand the experiences of senior women faculty medical and basic science academicians in order to illuminate the ways in which gendered processes have affected and still affect women. My research puts more emphasis on the way in which women negotiate the tension in these realms. This project deepens the understanding of this topic and also demonstrates how women enact a justification of the academic institution despite the problematic way they must enact their presentation of self.

The implications of this contribution to the ongoing conversation about women in medicine and science is that with greater knowledge of how women negotiate self and environment we can show how professional women in academic medicine and basic science navigate to survive and succeed in their particular professional settings. However, this strategic negotiation is symptomatic of being the “other”, a woman, in predominantly male spaces, which happens to women in all social institutions. Without the structural change to social institutions that would create space for women (and other disadvantaged groups) to fully integrate, these processes of isolation and exclusion are likely to continue. We cannot place the onus on women to make better choices or simply to lean in to the table. The environment itself must be challenged.

Limits

As with any study, there are limitations that might prevent the researcher from adequately answering the research question. This project, as an oral history of twenty-six senior women faculty at an academic medical center in the Midwest provides very rich in-depth qualitative data, however, this type of research design does not provide the population that would suggest generalizability to the larger population, at another institution, or in

another geographic region. What is lost in breadth of generalizability, however, is found with the deeper understanding of these women's narratives. Because this study was conducted in the Midwest, gendered processes and experiences might be different than a study done in another city, region, state, or country. The women in this study were predominately white, with most of them embodying middle to upper class comportment. The gendered processes in this group of women might not translate to women with less education, women who are not white, or women in a lower socio-economic class.

Of the women interviewed, twenty-three are white, one woman is black, one woman is Filipino, and one woman is multiethnic (white and Japanese). Thus the women I interviewed who identified themselves to me as a racial minority were 11.5 percent of the women in the study. I find it imperative to note that all three non-white women brought negotiations of race into their interview responses. Although this study did not particularly look at race, class, or sexual orientation as a means of studying the self and environment negotiations of these women, and I do not make any claims based on these social attributes, a study that seeks to understand how these additional intersections of identity would affect a woman's negotiation of self and environment is aptly needed, as research would suggest that these women are doubly disenfranchised.

Oral histories require the participant to recall information from their past, and while this can provide an historical account of a phenomena, there is the possibility that the women in this study might have recalled their experiences differently than they actually transpired (Swain 2003). This is the risk that is found with any personal historical account. Those with higher educations can sometimes rework a memory with theoretical or empirical knowledge that can now be employed, yet at the time of the experience a different process might have

been at work. Because these are reconstructed memories about past experiences, there is no way to know if they are as empirically valid as real time events.

Also, perhaps a sort of “self-selection” happens when women that are senior faculty and thus tenured are interviewed. The women studied could have been more tenacious than most women their age in that socio-historical context. I did not have the chance to question women who had been in medical and graduate school and did not persist long enough to become tenured. Work that has interviewed women that have not persisted has shown that women gave reasons of alienation and the difficulty of managing the work life balance as why they left academia (Lowenstein, Fernandez, and Crane 2007).

However, the strengths of this study are also compelling to examine. Because of the qualitative nature, the data is extremely rich and descriptive, with a very in depth account. With this analysis, my goal was to explore if and how women were “othered” in the medical and basic science academy and how these women as medical doctors and basic scientists negotiated self and environment in order to downplay their “otherness” to achieve rank in a previously predominantly male field. It is unclear if another researcher would find the same themes in their analysis of the interview data. However, the themes found were highly consistent with previous data that has explored the reasons women academic medical doctors and basic scientists are seen as anomalies instead of the norm. This study adds to that existing research in an attempt to further understand the gendered organizational climate in which women find themselves.

Future Research

Throughout the interview process, the most salient question that formed as I listened to the women's response was "would a man say that?" It is clear that the structure of gender in our lives denies us the chance to speculate how we would act differently in the same situations if we were another gender. Yet one does wonder what exactly is processed by one gender over another, especially in male dominated spaces such as basic science and medicine. As Elianne Riska (2001) says in her study about women in medicine, "Something happens to women during their training to become physicians that does not happen to the same extent to the men" (2001; pg 53), and I want to know what that something is. A comparative oral history of male academic basic scientists and clinicians would be helpful in comparing the two groups.

In Kanter's (1977) research, the men studied were not overtly aware of their desire for conformity. I would be curious to see if this is still the case in most social institutions today. Therefore, future research asking male physicians about their gendered experiences in medical school, residency, and in their medical and basic science professions would help to compare and contrast the gendered processes that women undergo in the same institutions. Furthermore, research that explores women in medical school today to compare their responses to the women I interviewed would more clearly demonstrate the socio-historical context in which women found themselves. Moreover, by problematizing the extra work a woman must do in order to move up in tenured positions in gendered organizations, attention can then be paid to how women are structurally constrained. It is possible to understand how these processes are historically specific and contextualized, and thus pragmatic solutions to this troubling phenomenon are needed. Without the type of research that shows that women

are still perceived as the other and must work to negotiate these spaces, the common belief that the doors have been completely opened for women will create a dissonance between reality and belief in society's ideas of gender equality. Thus, as I argue in this paper, understanding the work women do to negotiate the tensions between their self (agency) and environment (structure) in order to become tenured informs the gendered organization literature with new insight into how women enact their agency in institutions, and reminds us to strive to fully understand the empowerment of women.

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Appendix: Interview Guide for the Female Professor Oral History Project at the University of Kansas

A. Purpose of the Interview

Provide useful information for young women professionals

Capture information about the challenges the respondent has faced as a woman in a male dominated field.

Others

- High School Students
- General Public – Philanthropy
- WIMS Panel Discussions

B. Questions

Part 1: Specialty and Background

1. Scope of Professional Work

I'd like to get a picture of the scope of your professional work. Tell me about your areas of specialization.

What inspired you to choose this specialty? (Was there a person? A life event?)

For young people:

High school students might be listening to this interview.

How would you describe your specialty to a young person?

When did you realize that you wanted to go into medicine?

What experiences led you to science and medicine?

Was there something that happened in high school or before?

Of the many things you have done over your career, what are you most proud of?

- Success statement, successful patient, research, discovery

2. The “Landscape” of Medicine

I'd like to get a ‘big picture’ overview of what the medical profession was like for a woman when you began your career.

How many women were involved as students? As teachers?

What kind of work expectations were there for women?

What about how school or work influenced family life?

3. Evolution of Career

- Tell me about the key moments in your career. This could be a key moment of growth, transition, change, success, or integration.
 - How did this change your career direction?
 - What did you learn?
 - How did this change your practice (in research, clinical, administrative)?

Part 2: Information for young women professionals.

1. What advice would you give to young women today to help them negotiate professional challenges they may face because they are women?

2. *Mentoring*

What qualities should a young woman look for in a mentor?

What should more senior women think about in order to successfully mentor other women?

What impact can a good mentor have on a woman's career?

Tell me about your significant mentors.

How did this relationship develop?

- Who instigated the relationship?

How did the mentor help your career?

3. *Sponsorship*

A. Now I want to introduce the idea of a special mentor. A sponsor is a little different than a mentor. New ideas about sponsorship vs. mentorship are changing the way these roles are perceived. A mentor is someone who acts as a sounding board or a shoulder to cry on, offering advice as needed and support and guidance as requested. Mentors might not expect anything viable from the mentee in return. However, a sponsor is much more vested in their protégés, offering not just guidance but actively advocating for them and even taking responsibility for their advancement because they believe in them.

B. Do you think any of your mentors were sponsors?

C. Tell me about her/him. (Was it significant that this sponsor was a wo/man?)

Did you see a gender difference in mentoring styles between men and women?

D. How did that person shape your career? Or manage your career?

4. *Part – Time Work:*

A. Today more women in medicine are working part time.

B. Did you ever consider working part time?

C. What prompted your consideration?

D. What factors were involved in your decision?

E. Did you work part time?

F. How did (would have) part time works affect(ed) your career development?

G. Looking back would you have made the same decision?

H. What advice would you give today to young women who are thinking about part-time work?

5. *Leadership development*

A. How do you think women can best prepare themselves for leadership roles, especially in contexts still dominated by men?

B. How did you develop your leadership abilities?

C. What advice would you give to younger women who have leadership ambitions?

Part 3: Experience as a Woman Professional

1. Handling Challenges and Obstacles

A. I'd like to get a picture of how you were treated as a woman professional.

- a. How were you treated by peers?
- b. By those in authority
- c. By those in lower positions (interns or residents)
- d. Support staff (nurses)
- e. Patients (Were you taken seriously by your patients?)

B. Tell me about situations you recall and how you handled them.

- Being ignored, being invisible, not make a wave
- Being ignored in meetings
- Raising a point only to have a male colleague take credit for it
- Performance pressure
- Socialization
- Birth control

B. Tell me about ways in which you proactively worked against these pressures to build your credibility and visibility as a woman professional.

C. I'd like you to compare your experience with what women face today in the profession. In what ways do women face similar issues? How are things different?

D. What needs to change to bring real gender equality to your field?

Part 4: Looking back at Career and Personal Decisions:

A. There are lots of instances where career affects personal decisions and where personal decisions affect a career. Tell me about a moment when you faced that kind of situation. Looking back, would you still make the same decision? Why?

B. I asked you earlier about accomplishments. What about things left undone. Are there any projects that you wish you could have completed? Roles you wish you could have taken on? Skills you wish you could have developed? Why were you not able to complete fulfill these goals? What was the effect?

C. How do you think being a physician has affected (and still affects) your social and personal relationships. I'm thinking here of the development of friendships, intimate relationships, and connections with family.

D. What impact has your work had on your leisure time? What decisions have you made or had to make about the balance of work and leisure. How has work effected your leisure activities and hobbies.